Hand Injury Wound/Scar Hydrogel Sheeting Prescription

PATIENT INFORMATION

Patient Name _____ M / F

Address _____

City _____ State _____ Zip _____

Tel _____ ☐ Patient notified of order

Date of Birth _____

Email Address _____

Responsible Party _____ Tel _____

Caregiver _____ Tel _____

Is patient being seen by Home Health Agency? ☐ Yes ☐ No

Avogel NDC Codes: : (1) 4"x4" sheet; NDC 76170-0104-43
(2) 8"x8" sheet; NDC 76170-0108-83
(3) 6"x48" roll. NDC 76170-0164-83

INSURANCE INFORMATION

Primary ins Co _____

ID # _____ Tel _____

Group or Claim # _____

Secondary Insurance Co _____

ID # _____ Tel _____

Referring Agency _____

Address _____

City _____ State _____ Zip _____

Ordering Physician _____

Fax _____ Tel _____

Patient Next Appointment: —-Weeks ——Months

Wound Scar Assessment and Management Summary

DIAGNOSIS: POST-SURGICAL , POST-TRUAMA HAND AND EXTREMITY SCARRING

INITIAL CAUSE OF WOUND: ICD 10 _____

IF BURN WOUND: Initial Depth of burn? : Partial Full

CLOSED WOUND AND SCAR ASSESSMENT:

**Wound Location **	Type	Length cm	Width cm	**Initial Thickness/Stage**
1. L / R	CLOSED			Partial Full
2. L / R	CLOSED			Partial Full
3. L / R	CLOSED			Partial Full
Freq. of Changes : Weekly,			Secure with : Surgilast (or equiv) or compression garment.	
Instructions : **Apply** Avogel to wound 18 hours /day; **Reuse** Avogel dressing for 5-7 days; **Replace** Avogel 5-7 days				

Total Avogel _____ sheets for 30-DAY supply ____ ; Duration of need: ☐ 30 days ☐ 60 days ☐ 90 days

Assessment Performed By: _____ ; Date: _____
Signature and Title

Physician's Signature (Required) _____ Date: _____

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